IC 12-15-13

Chapter 13. Provider Payment; General

IC 12-15-13-0.5

"Clean claim" defined

Sec. 0.5. (a) Except as provided in section 0.6 of this chapter, as used in this chapter, "clean claim" means a claim submitted by a provider for payment under the Medicaid program that can be processed without obtaining additional information from:

(1) the provider of the service; or

(2) a third party.

(b) The definition under subsection (a):

(1) includes a claim with errors originating in the state's claims processing system; and

(2) does not include a claim:

(A) from a provider who is under investigation for fraud or abuse (as used in 42 CFR 447.45(b); or

(B) under review for medical necessity.

As added by P.L.107-1996, SEC.2 and P.L.257-1996, SEC.2.

IC 12-15-13-0.6

"Clean claim" defined for purposes of IC 12-15-14

Sec. 0.6. (a) "Clean claim", as the term applies to payments to nursing facilities under IC 12-15-14, means a claim submitted by a provider for payment that meets the following conditions:

(1) Contains the following locators:

(A) Type of bill.

(B) Coverage dates.

(C) Bill status.

(D) Revenue codes.

(E) Rate of payment.

(F) Service units.

(G) Total charges.

(H) Provider number.

(I) Third party prior payments.

(J) Estimated amount due.

(K) Recipient number.

(L) Provider signature.

(M) Provider name.

(N) Number of covered days of service.

(O) Date of admission.

(P) Condition codes.

(Q) Occurrence codes and dates.

(R) Value codes and amounts.

(S) Third party liability payor name.

(T) Recipient name.

(U) Admitting diagnosis.

(V) Attending physician ID number.

(2) Has correct and valid information for each of the locators required by subdivision (1).

(3) The recipient for whom the claim is submitted is eligible for Medicaid on the date for which the service is billed.

(4) The office has approved the level of care for:

(A) the recipient; and

(B) the facility;

for the dates for which the service is billed.

(5) The provider is eligible to render service on the date for which the service is billed.

(6) The claim does not duplicate a claim already paid.

(b) The definition under subsection (a):

(1) includes a claim with errors originating in the state's claims processing system; and

(2) does not include a claim:

(A) from a provider who is under investigation for fraud or abuse (as used in 42 CFR 447.45(b)); or

(B) under review for medical necessity.

As added by P.L.107-1996, SEC.3 and P.L.257-1996, SEC.3.

IC 12-15-13-0.7

Addition, deletion, or modification of locators

Sec. 0.7. The office may adopt rules under IC 4-22-2 that add, delete, or modify the locators contained in section 0.6(a)(1) of this chapter as necessary to conform with:

(1) changes in federal law or regulation; or

(2) directives from the United States Centers for Medicare and Medicaid Services.

As added by P.L.107-1996, SEC.4 and P.L.257-1996, SEC.4. Amended by P.L.66-2002, SEC.3.

IC 12-15-13-1

Payment, denial, or suspension of claims submitted by nursing facilities; time; notice of suspension or denial

Sec. 1. (a) This section applies only to claims submitted for payment by nursing facilities.

(b) The office shall pay, deny, or suspend each claim submitted by a provider for payment under the Medicaid program not more than:

(1) twenty-one (21) days after the date a claim that is filed electronically; or

(2) thirty (30) days after the date a claim that is filed on paper;

is received by the office or, if IC 12-15-30 applies, by the contractor under IC 12-15-30.

(c) The office shall pay each clean claim.

(d) The office may deny or suspend a claim that is not a clean claim. If the office denies a provider's claim for payment, the office shall notify the provider of each reason the claim was denied.

(e) If the office suspends a provider's claim for payment under the Medicaid program, the office shall notify the provider of each reason the claim was suspended.

As added by P.L.2-1992, SEC.9. Amended by P.L.10-1994, SEC.4;

P.L.107-1996, SEC.5; P.L.257-1996, SEC.5.

IC 12-15-13-1.5

Payment of interest on claims submitted by nursing facilities

Sec. 1.5. (a) This section applies only to claims submitted for payment by nursing facilities.

(b) If the office:

(1) fails to pay a clean claim in the time required under section 1(a) of this chapter; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the office shall pay the provider interest on the Medicaid allowable amount of the claim.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under section 1(b)(1) of this chapter; or

(B) thirty-one (31) days after the date the claim is filed under section 1(b)(2) of this chapter; and

(2) stops accruing on the date the office pays the claim.

(d) The office shall pay interest under subsection (b) at the same rate as determined under IC 12-15-21-3(7)(A).

As added by P.L.107-1996, SEC.6 and P.L.257-1996, SEC.6.

IC 12-15-13-1.6

Payment, denial, or suspension of claims; notice of suspension or denial

Sec. 1.6. (a) This section does not apply to claims submitted for payment by nursing facilities.

(b) The office shall pay or deny each clean claim in accordance with section 1.7 of this chapter.

(c) The office shall deny or suspend each claim that is not a clean claim in accordance with subsection (d).

(d) The office shall deny or suspend each claim that is:

(1) not a clean claim; and

(2) submitted by a provider for payment under the Medicaid program;

not more than thirty (30) days after the date the claim is received by the office or, if IC 12-15-30 applies, by the contractor under IC 12-15-30.

(e) If the office denies a provider's claim for payment under subsection (d) or section 1.7 of this chapter, the office shall notify the provider of each reason the claim was denied.

(f) If the office suspends a provider's claim for payment under subsection (d), the office shall notify the provider of each reason the claim was suspended.

As added by P.L.107-1996, SEC.7 and P.L.257-1996, SEC.7.

IC 12-15-13-1.7

Timing of payment or denial of claims; payment of interest

Sec. 1.7. (a) This section does not apply to claims submitted for payment by nursing facilities.

(b) The office shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(c) If:

(1) the office fails to pay or deny a clean claim in the time required under subsection (b); and

(2) the office or a contractor of the office under IC 12-15-30 subsequently pays the claim;

the office shall pay the provider that submitted the claim interest on the Medicaid allowable amount of the claim paid under this section.

(d) Interest paid under subsection (c) shall:

(1) begin accruing:

(A) twenty-two (22) days after the date the claim is filed under subsection (b)(1); or

(B) thirty-one (31) days after the date the claim is filed under subsection (b)(2); and

(2) stop accruing on the date the claim is paid.

(e) In paying interest under subsection (c), the office shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

As added by P.L.107-1996, SEC.8 and P.L.257-1996, SEC.8.

IC 12-15-13-2

Payments to providers; requirements; federal law or regulations specifying reimbursement criteria

Sec. 2. (a) Except as provided in IC 12-15-14 and IC 12-15-15, payments to Medicaid providers must be:

(1) consistent with efficiency, economy, and quality of care; and

(2) sufficient to enlist enough providers so that care and services are available under Medicaid, at least to the extent that such care and services are available to the general population in the geographic area.

(b) If federal law or regulations specify reimbursement criteria, payment shall be made in compliance with those criteria.

As added by P.L.2-1992, SEC.9. Amended by P.L.278-1993(ss), SEC.27.

IC 12-15-13-3

Overpayments; provider options; hospitals; interest; rules

Sec. 3. (a) If the office of the secretary believes that an

overpayment to a provider has occurred, the office of the secretary may do the following:

(1) Notify the provider in writing that the office of the secretary believes that an overpayment has occurred.

(2) Request in the notice that the provider repay the amount of the alleged overpayment, including interest from the date of overpayment.

(b) A provider who receives a notice and request for repayment under subsection (a) may elect to do one (1) of the following:

(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office of the secretary, including interest from the date of overpayment.

(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office of the secretary.

(3) Request a hearing not later than sixty (60) days after receiving notice from the office of the secretary and not repay the alleged overpayment, except as provided in subsection (d).

(c) If:

(1) a provider elects to proceed under subsection (b)(2); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider does not owe the money that the office of the secretary believed the provider owed;

the office of the secretary shall return the amount of the alleged overpayment and interest paid and pay the provider interest on the money from the date of the provider's repayment.

(d) If:

(1) a provider elects to proceed under subsection (b)(3); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money;

the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

(e) Interest that is due under this section shall be paid at a rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c) as follows:

(1) Interest due from a provider to the state shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(2) Interest due from the state to a provider shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(f) Proceedings under this section are subject to IC 4-21.5.

As added by P.L.152-1995, SEC.10. Amended by P.L.107-1996, SEC.9; P.L.257-1996, SEC.9; P.L.78-2004, SEC.3.

IC 12-15-13-4
Reserved

IC 12-15-13-5

Reserved

IC 12-15-13-6

Notices or bulletins

Sec. 6. (a) A notice or bulletin that is issued by:

(1) the office;

(2) a contractor of the office; or

(3) a managed care plan under the office;

concerning a change to the Medicaid program that does not require use of the rulemaking process under IC 4-22-2 may not become effective until forty-five (45) days after the date the notice or bulletin is mailed to the parties affected by the notice or bulletin.

(b) The office must mail a notice or bulletin described in subsection (a) within five (5) business days after the date on the notice or bulletin.

As added by P.L.42-1995, SEC.22.

IC 12-15-13-7

Permitted forms

Sec. 7. (a) The office and an entity with which the office contracts for the payment of claims shall accept claims submitted on any of the following forms by an individual or organization that is a contractor or subcontractor of the office:

(1) HCFA-1500.

(2) HCFA-1450 (UB92).

(3) American Dental Association (ADA) claim form.

(4) Pharmacy and compound drug form.

(b) The office and an entity with which the office contracts for the payment of claims:

(1) may designate as acceptable claim forms other than a form listed in subsection (a); and

(2) may not mandate the use of a crossover claim form.

As added by P.L.256-2001, SEC.3.

IC 12-15-13-7.2

Use of diagnostic or procedure codes

Sec. 7.2. (a) As used in this section, "provider" has the meaning set forth in IC 27-8-11-1.

(b) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) the office shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the office pays claims for services provided

under the Medicaid program; and

(2) a provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for services provided under the Medicaid program.

(c) If a provider provides services that are covered under the Medicaid program:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (b); and

(2) before the office begins using the most current version of the diagnostic or procedure code;

the office shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

As added by P.L.161-2001, SEC.2. Amended by P.L.66-2002, SEC.4.